

		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0027581</u></p> <p>Facility Name: <u>Manorcare at Champaign</u></p> <p>Address: <u>309 E. Springfield</u> <u>Champaign</u> <u>61820</u> Number City Zip Code</p> <p>County: <u>Champaign</u></p> <p>Telephone Number: <u>'(217) 352 - 5135</u> Fax # <u>'(217) 352 - 9139</u></p> <p>IDPA ID Number: <u>520886946008</u></p> <p>Date of Initial License for Current Owners: <u>11 / 01 / 81</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Craig Dekany, Reimb. Manager</u> Telephone Number: <u>(419) 252 - 5740</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>6 / 01 / 99</u> to <u>5 / 31 / 00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Barry Lazarus</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Title) <u>VP of Reimbursement</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Barry Lazarus</u>	Paid Preparer	(Title) <u>VP of Reimbursement</u>	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																	
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	(Signed) _____ (Date) _____																																		
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	(Firm Name & Address) _____																																		
	(Telephone) <u>()</u> Fax # <u>()</u>																																		

DPA 3745 (N-4-99)

IL478-2471

Print Preview

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Manorcare at Champaign# 0027581 Report Period Beginning: 6 / 01 / 99 Ending: 5 / 31 / 00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>102</u>	Skilled (SNF)	<u>102</u>	<u>37,332</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>102</u>	TOTALS	<u>102</u>	<u>37,332</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,468</u>	<u>526</u>	<u>3,236</u>	<u>5,230</u>	8
9	SNF/PED					9
10	ICF	<u>16,641</u>	<u>11,387</u>	<u>77</u>	<u>28,105</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,109</u>	<u>11,913</u>	<u>3,313</u>	<u>33,335</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.29%D. How many bed-hold days during this year were paid by Public Aid?
14 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 11 / 01 / 81J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 11 / 01 / 81 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 18 and days of care provided 2994Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☒Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 6 / 01 / 99 Ending: 5 / 31 / 00
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

		Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
	Operating Expenses	Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	156,619	10,419	6,692	173,730	3,334	177,064	0	177,064		1
2	Food Purchase		118,564		118,564		118,564	(3,917)	114,647		2
3	Housekeeping	68,163	9,133	265	77,561		77,561	0	77,561		3
4	Laundry	34,177	10,472	433	45,082		45,082	0	45,082		4
5	Heat and Other Utilities			90,867	90,867	6,946	97,813	0	97,813		5
6	Maintenance	30,796	26,604	28,120	85,520		85,520	0	85,520		6
7	Other (specify):*							0			7
8	TOTAL General Services	289,755	175,192	126,377	591,324	10,280	601,604	(3,917)	597,687		8
	B. Health Care and Programs										
9	Medical Director			9,250	9,250	2,600	11,850	0	11,850		9
10	Nursing and Medical Records	1,019,938	98,372	3,749	1,122,059	10,553	1,132,612	0	1,132,612		10
10a	Therapy	141,606	3,806	22,968	168,380		168,380	0	168,380		10a
11	Activities	60,032	1,998	5,598	67,628		67,628	0	67,628		11
12	Social Services	36,266	74		36,340	3,381	39,721	0	39,721		12
13	Nurse Aide Training							0			13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16	TOTAL Health Care and Programs	1,257,842	104,250	41,565	1,403,657	16,534	1,420,191		1,420,191		16
	C. General Administration										
17	Administrative	91,575		167,331	258,906	(46,240)	212,666	0	212,666		17
18	Directors Fees							0			18
19	Professional Services			27,338	27,338	(9,879)	17,459	(17,459)			19
20	Dues, Fees, Subscriptions & Promotions			38,030	38,030		38,030	(21,902)	16,128		20
21	Clerical & General Office Expenses	131,894	7,716	45,026	184,636		184,636	(12,984)	171,652		21
22	Employee Benefits & Payroll Taxes			345,491	345,491	783	346,274	0	346,274		22
23	Inservice Training & Education			3,725	3,725		3,725	0	3,725		23
24	Travel and Seminar			13,593	13,593		13,593	0	13,593		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			50,567	50,567		50,567	0	50,567		26
27	Other (specify):*							0			27
28	TOTAL General Administration	223,469	7,716	691,101	922,286	(55,336)	866,950	(52,345)	814,605		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,771,066	287,158	859,043	2,917,267	(28,522)	2,888,745	(56,262)	2,832,483		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 6 / 01 / 99 Ending: 5 / 31 / 00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			224,572	224,572	11,994	236,566	(39,441)	197,125			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			27,337	27,337	16,528	43,865	(1,135)	42,730			32
33	Real Estate Taxes			39,994	39,994		39,994	0	39,994			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			6,770	6,770		6,770	0	6,770			35
36	Other (specify):*							0				36
37	TOTAL Ownership			298,673	298,673	28,522	327,195	(40,576)	286,619			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		82,534		82,534		82,534	0	82,534			39
40	Barber and Beauty Shops		17,579		17,579		17,579	0	17,579			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			55,998	55,998		55,998	0	55,998			42
43	Other (specify):*		10,198		10,198		10,198	0	10,198			43
44	TOTAL Special Cost Centers		110,311	55,998	166,309		166,309		166,309			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,771,066	397,469	1,213,714	3,382,249	0	3,382,249	(96,838)	3,285,411			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning: 6 / 01 / 99

Ending: 5 / 31 / 00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,917)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,135)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,086)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(39,441)	30		15
16	Personal Expenses (Including Transportation)	(867)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(17,459)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,031)	21		24
25	Fund Raising, Advertising and Promotional	(21,902)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (96,838)		\$	30

OHF USE ONLY

48		49		50		51		52	
----	--	----	--	----	--	----	--	----	--

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
		(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (96,838)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Print Preview

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Manorcare at Champaign

0027581 Report Period Beginning:

6 / 01 / 99

Ending: 5 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses												SUMMARY TOTALS (to Sch V, col.7)	
		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I		
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,917)	0	0	0	0	0	0	0	0	0	0	(3,917)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,917)	0	0	0	0	0	0	0	0	0	0	(3,917)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(17,459)	0	0	0	0	0	0	0	0	0	0	(17,459)	19
20	Fees, Subscriptions & Promotions	(21,902)	0	0	0	0	0	0	0	0	0	0	(21,902)	20
21	Clerical & General Office Expenses	(12,984)	0	0	0	0	0	0	0	0	0	0	(12,984)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(52,345)	0	0	0	0	0	0	0	0	0	0	(52,345)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(56,262)	0	0	0	0	0	0	0	0	0	0	(56,262)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Manorcare at Champaign**

0027581

Report Period Beginning:

6 / 01 / 99 Ending:

5 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(39,441)	0	0	0	0	0	0	0	0	0	0	(39,441)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,135)	0	0	0	0	0	0	0	0	0	0	(1,135)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(40,576)	0	0	0	0	0	0	0	0	0	0	(40,576)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(96,838)	0	0	0	0	0	0	0	0	0	0	(96,838)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number

Manorcare at Champaign

#

0027581

Report Period Beginning: 6 / 01 / 99

Ending:

5 / 31 / 00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Previe](#)

STATE OF ILLINOIS

Page 8

Facility Name & ID Number Manorcare at Champaign# 0027581

Report Period Beginning:

6 / 01 / 99Ending: 5 / 31 / 00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

HCR ManorCare, Inc.

Street Address

333 North Summit St.

City / State / Zip Code

Toledo, OH 43604

Phone Number

(419) 252 - 5500

Fax Number

(419) 254 - 5494

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	100,182,693	357 Nurs. Fac.	\$ 388478	\$ 221,496	150,803	\$ 585	1
2	5	Utilities	Accumulated Cost	100,182,693	357 Nurs. Fac.	4614666		150,803	6,946	2
3	10	Nursing	Accumulated Cost	100,182,693	357 Nurs. Fac.	6247503	4,177,723	150,803	9,404	3
4	17	General & Administrative	Accumulated Cost	100,182,693	357 Nurs. Fac.	80443795	26,746,978	150,803	121,090	4
5	22	Employee Benefit	Accumulated Cost	100,182,693	357 Nurs. Fac.	520233		150,803	783	5
6	30	Depreciation	Accumulated Cost	100,182,693	357 Nurs. Fac.	7968019		150,803	11,994	6
7	32	Interest	Direct Allocation	1		16,528		1	16,528	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 100,199,222	\$ 31,146,197		\$ 167,330	25

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Facility Name & ID Number Manorcare at Champaign# 0027581

Report Period Beginning:

6 / 01 / 99

Ending:

5 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Conv. Sub. Debentures		X	Facility			\$ 522,057	\$ 522,057			\$ 16,528	1	
2	Champaign National Bank						1,425,601	1,375,116			0	2	
3	Debt Discount						(255,025)	(246,124)			26,945	3	
4												4	
5												5	
	Working Capital												
6												6	
7								Interest Income Other			392	7	
8								Interest Income Offset			(1,135)	8	
9	TOTAL Facility Related						\$ 1,692,633	\$ 1,651,049			\$ 42,730	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 1,692,633	\$ 1,651,049			\$ 42,730	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **Manorcare at Champaign**

0027581

Report Period Beginning:

6 / 01 / 99

Ending:

5 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$	39,994	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	39,994	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	39,994	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	39,994	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1995	36,428	8
1996	38,452	9
1997	39,764	10
1998	40,027	11
1999	42,028	12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$ 13
14	PLUS APPEAL COST FROM LINE 5	\$ 14
15	LESS REFUND FROM LINE 6	\$ 15
16	AMOUNT TO USE FOR RATE CALCULATION	\$ 16

R/E Tax Payments

Fall 1999	20013
Spring 2000	19981

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

A. Square Feet: 23,814

B. General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories 3

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground! (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1968	\$ 54,050	1
2					2
3	TOTALS			\$ 54,050	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning:

6 / 01 / 99 Ending:

5 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102			1968	\$ 1,201,229	\$ 40,205		\$ 40,205	\$	\$ 957,298	4
5											5
6											6
7											7
8											8
PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3											
9	Current Year Depreciation					101,590		101,590		500,783	9
10				1985	3,107						10
11				1986	8,851						11
12				1987	74,516						12
13				1988	41,139						13
14				1989	1,297						14
15				1990	20,319						15
16				1991	50,575						16
17				1992	374,174						17
18				1993	51,354						18
19				1994	48,400						19
20				1995	229,982						20
21	ELECTRICAL WORK			1996	17,102						21
22	WALL VINYL			1996	10,548						22
23	VINYL FLOORING			1996	14,858						23
24	INSTALL CAMERA SYSTEM			1996	1,453						24
25	REMODEL 13 ROOMS AND LOBBY			1996	35,665						25
26	HVAC			1996	21,101						26
27	ROOF WORK			1996	1,365						27
28	CORPORATE OVERHEAD			1996	7,272						28
29	CONCRETE WORK			1996	3,880						29
30	CARPET			1996	5,900						30
31	DIGITAL KEYPAD			1996	1,915						31
32	INSTALL EMERGENCY GENERATOR			1996	44,791						32
33	INSTALL CIRCUIT BREAKER			1996	3,289						33
34	HVAC			1996	1,867						34
35	INSTALL COVE BASE/SIGNS			1996	2,612						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 141,795		\$ 141,795	\$	\$ 1,458,081	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0027581

Report Period Beginning:

6 / 01 / 99 Ending:

Page 12A

5 / 31 / 00

Facility Name & ID Number Manorcare at Champaign

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9		WALLCOVERINGS		1997	12,165						9
10		CARPET		1997	1,639						10
11		INSTALL HYDROLIC CYLINDER		1997	14,249						11
12		UNIT PROTECTION SWITCH		1997	6,354						12
13		FURNISH/INSTALL TILES		1997	16,476						13
14		HANDRAILS		1997	5,661						14
15		RETIREMENTS		1987	(55,068)						15
16		RETIREMENTS		1992	(6,784)						16
17		PLUMBING		1997	7,610						17
18		VINYL TILE		1997	1,643						18
19		HAND RAILS		1997	1,450						19
20		FACILITY PLAN ALLOC		1997	2,759						20
21		INSTALL GATES		1997	1,226						21
22		CORNER GUARDS		1997	314						22
23		ELECTRICAL		1998	2,598						23
24		REPLACE WINDOWS		1998	2,763						24
25		INSTALL QUARRY TILE		1998	1,640						25
26		INSTALL DUCTWORK		1998	2,350						26
27		CORPORATE OVERHEAD		1998	1,702						27
28		SECURITY SYSTEM		1998	33,542						28
29		ENTRYWAY/PARKING LOT WORK		1998	2,209						29
30		ELEVATOR EQUIP EVAL		1998	700						30
31		CARPENTRY		1998	355						31
32		WALLPAPER		1998	400						32
33		CARPETING/FLOORING		1998	2,471						33
34		PLUMBING		1998	9,690						34
35		ELECTRICAL		1998	1,367						35
36		PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3			\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0027581

Report Period Beginning:

6 / 01 / 99 Ending:

Page 12B

5 / 31 / 00

Facility Name & ID Number Manorcare at Champaign

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	HVAC			1998	565						9
10	PAINTING/WALLCOVERING			1998	10,552						10
11	GENERAL REQ			1998	1,500						11
12	CONTRACTORS			1998	2,507						12
13	ROOFING			1998	500						13
14	DOOR/WINDOW			1998	2,456						14
15	ELEVATORS			1998	3,433						15
16	SINAGE			1998	11,862						16
17	CARPETING			1999	5,993						17
18	CALL LIGHT SYSTEM			1999	42,342						18
19	1997 BILLING FOR CONSTRUCTION			1999	20,476						19
20	INSTALL SECURE DOOR KIT			1999	3,753						20
21	FABRIC FOR PATIENT FURNITURE			1999	121						21
22	PLUMBING PARTS, LABOR, RENOVATION			1999	900						22
23	FABRIC FOR PATIENT FURNITURE			1999	674						23
24	PAINT, WALLPAPER, CORRIDOR			1999	8,471						24
25	FIRE-SMOKE DAMPERS			1999	(581)						25
26	REMODEL KITCHEN RECEPTACLES			1999	4,800						26
27	NEW SHOWER BASE			1999	6,870						27
28	DISCOUNT, CAIN'S ROOFING			1999	(2,221)						28
29	CERAMIC TILE - 2 SHOWERS			1999	2,718						29
30	FIRE & SMOKE DAMPERS			1999	9,527						30
31	PROCARE 1000 NURSE CALL			1999	17,494						31
32	DRAIN REPLACEMENT			2000	875						32
33	DRYWALL REPAIR			2000	600						33
34	ZSN REPAIR			1999	1,307						34
35	CONTROL PANEL REPLACED			2000	984						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
					\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0027581

Report Period Beginning:

6 / 01 / 99 Ending: 5 / 31 / 00

Page 12C

Facility Name & ID Number Manorcare at Champaign

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	WIRING FOR CAMERA SECURITY SYSTEM			2000	6,979						9
10	WALLCOVERINGS			2000	364						10
11	VINYL WALLCOVERINGS			2000	1,662						11
12	WALLCOVERING			2000	1,566						12
13	CLOSET DOORS			2000	13,140						13
14	WALLCOVERING			2000	37						14
15	RETIREMENTS			2000	(64,936)						15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0027581

Report Period Beginning:

6 / 01 / 99 Ending: 5 / 31 / 00

Page 12D

Facility Name & ID Number Manorcare at Champaign

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

STATE OF ILLINOIS

Page 13

Facility Name & ID Number Manorcare at Champaign# 0027581

Report Period Beginning:

6 / 01 / 99

Ending:

5 / 31 / 00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 400,108	\$ 43,336	\$ 43,336	\$		\$ 208,776	37
38	Current Year Purchases	41,140						38
39	Fully Depreciated Assets	(44,413)						39
40	Home Office			11,994	11,994			40
41	TOTALS	\$ 396,835	\$ 43,336	\$ 55,330	\$ 11,994		\$ 208,776	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	N/A			\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 185,131	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 197,125	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 11,994	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,666,857	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Step-Up Building	\$ 1,064,894	\$ 39,441	\$ 732,936	52
53					53
54					54
55					55
56					56
57	TOTALS	\$ 1,064,894	\$ 39,441	\$ 732,936	57

G. Construction-in-Progress

	Description	Cost	
58	Construction in Progress	\$ (308)	58
59			59
60			60
61		\$ (308)	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

[Print Preview](#)

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,770

Description: 02 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number Manorcare at Champaign # 0027581 Report Period Beginning: 6 / 01 / 99 Ending: 5 / 31 / 00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	10a	1,758 hrs	\$ 37,792		
2	Licensed Speech and Language Development Therapist	10a	1,315 hrs	42,722		1,295	67	1,315	44,084	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a	2,980 hrs	61,092		5,421	2,412	2,980	68,925	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39	# of prescripts			11,384	82,534		93,918	9	
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									12	
13	Other (specify):									13	
14	TOTAL			\$ 141,606		\$ 22,968	\$ 86,340	6,053	\$ 250,914	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning: 6 / 01 / 99

Ending:

5 / 31 / 00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 5 / 31 / 00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 120,145	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 12,936)	274,017		3
4	Supply Inventory (priced at)	14,000		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,513		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 411,675	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	104,456		13
14	Buildings, at Historical Cost	3,481,819		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	396,835		16
17	Accumulated Depreciation (book methods)	(2,399,816)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	(308)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,582,986	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,994,661	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 33,752	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	102,033		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,410		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,994		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	34,440		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 222,629	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,128,992		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,128,992	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,351,621	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 643,040	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,994,661	\$	48

*(See instructions.)

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Facility Name & ID Number Manorcare at Champaign

0027581 Report Period Beginning: 6 / 01 / 99

Ending: 5 / 31 / 00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,542,033	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,542,033	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	230,081	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 230,081	17
	B. Transfers (Itemize):		
18	INTERDIVISION	(2,129,074)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (2,129,074)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 643,040	24 *

* This must agree with page 17, line 47.

Print Previe

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Manorcare at Champaign

0027581

Report Period Beginning: 6 / 01 / 99

Ending: 5 / 31 / 00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,037,603	1
2	Discounts and Allowances for all Levels	(979,823)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,057,780	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	447,116	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 447,116	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	867	12
13	Barber and Beauty Care	20,636	13
14	Non-Patient Meals	3,917	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,608	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,163	19
20	Radiology and X-Ray		20
21	Other Medical Services	108	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 106,299	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,135	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,135	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,612,330	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 591,324	31
32	Health Care	1,403,657	32
33	General Administration	922,286	33
	B. Capital Expense		
34	Ownership	298,673	34
	C. Ancillary Expense		
35	Special Cost Centers	166,309	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,382,249	40
41	Income before Income Taxes (line 30 minus line 40)**	230,081	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 230,081	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
 (This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	5,092	6,248	\$ 109,675	\$ 17.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,344	11,111	165,619	14.91	3
4	Licensed Practical Nurses	12,072	15,185	191,699	12.62	4
5	Nurse Aides & Orderlies	49,539	59,271	531,673	8.97	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,338	9,988	134,372	13.45	7
8	Rehab/Therapy Aides	815	1,129	7,234	6.41	8
9	Activity Director					9
10	Activity Assistants	6,772	7,555	60,032	7.95	10
11	Social Service Workers	1,608	1,906	36,266	19.03	11
12	Dietician	16,263	18,745	156,619	8.36	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	2,036	2,337	30,796	13.18	17
18	Housekeepers	8,247	9,655	68,163	7.06	18
19	Laundry	3,791	4,080	34,177	8.38	19
20	Administrator	1,832	1,872	91,575	48.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,115	10,859	131,894	12.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,319	2,521	21,272	8.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	138,183	162,462	\$ 1,771,066 *	\$ 10.90	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	11,850	9,8	36
37	Medical Records Consultant	Monthly	1,000	10,5	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	149	10,5	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	3,381	12,5	45
46	Other(specify)				46
47	Dietary	Monthly	2,749	1,5	47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,129		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	6 Amount of Expense Amortized Per Year									13
					5 FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

Print Previe

Facility Name & ID Number **Manorcare at Champaign**# **0027581**

Report Period Beginning:

6 / 01 / 99

Ending:

5 / 31 / 00**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA 3698
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? _____
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,064 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 55,998
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? YES Indicate the amount. \$ 3,917
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.